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Special Article

No-Fault Liability for Adverse Medical Results

Is It a Reasonable Alternative to the Present Tort System?

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At the request of CMA's Committee on Professional Liability, David S. Rubsamen, M.D., LL. B., has prepared a comprehensive study of the concept of "no-fault" liability for adverse medical results. In what undoubtedly will become a hallmark of further and future consideration of the application of the concept of "no-fault" to medical malpractice, the study concludes that this widely advocated concept is not a viable alternative to the present system of litagating medical malpractice claims. Instead, the study states that: "A no-fault system for compensating injured persons cannot be analyzed outside the context of the injury. . . . In such cases, pursuit of the question leads right back to a standard of care analysis, to conflicts between experts or textbooks or both, to lengthy hearings and even to the accusatory atmosphere—all of which the physician seeks to escape by finding an alternative to customary courtroom litigation."

The report cites, as additional weaknesses of a no-fault system for medical malpractice:

- *Parties in a professional liability action would be denied a jury trial or access to a judicial system based on tort law and its theory of recovery. In effect, physicians would continue to be confronted with accusations, but would lose their ability to respond effectively.*
- *There would be more pressure for defensive medicine.*
- *Rules providing for ease of administration would, because of necessary arbitrariness, virtually guarantee dissatisfaction with the "unjust" result in a significant number of cases.*
- *Patients (perhaps with unrealistic expectations) could easily regard an outcome which is less than they hoped for, as justifying compensation.*
- *Financing of a comprehensive system "would be prohibitive," and administrative problems "could be staggering."*

Dexter T. Ball, M.D., Chairman
CMA Committee on Professional Liability

NO ONE DOUBTS THAT THE TORT-COURT TRIAL system for professional liability cases contains profound defects. A steadily rising incidence of claims, the irrationality of 12 lay persons attempting to resolve frequently complex medical issues, the years of never-quite-absent anxiety if he has a case pending, plus the particularly distressing prospect of public trial and probably excoriating cross examination (all to be repeated if a new trial is granted by an appellate court) create a picture of torment for the sensitive phy-

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sician and at least of wasted time and unpleasant incidents even for the more resilient. The current claims frequency,[1] unless it drops considerably, makes the litigation experience a likely prospect for every California physician at some time in his career. And the whole problem is compounded by an instability in insurance rates which presages substantial yearly increases in premiums for at least that group of California physicians whose claims experience in recent years excludes them from the "preferred risk" classification.[2,3]

For the patient, the tort-courtroom litigation system is unsatisfactory. Leading plaintiff's attorneys in metropolitan centers allege that they turn away at least 90 percent of persons who feel they may have been negligently injured by a physician or a hospital employee. Some of these patients have valid claims which are too small to justify the necessary investment of the lawyer's time. Although among the remainder of cases a number must be essentially frivolous, it is logical to suppose there is a significant group of patients with substantial disabilities which are medically caused but do not seem associated with negligent care. And it is generally felt that patients who sue physicians in the more rural counties must have far stronger cases in order to win. Taken together, then, there is a significant group of uncompensated injuries which, although frequently not the fault of the physician in a legal sense, constitute for the patient a dismaying and perhaps expensive consequence of his medical care.

Even for the patient who is destined to win in court, the road is not free of obstacles. In San Francisco and Los Angeles there will be a substantial delay before trial. If the patient is successful, but the verdict is appealed, there will be additional delay.

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[1]Fourteen per 100 physicians in Northern California and probably not far behind that in Southern California, although recent data from that area are incomplete.

[2]Professional Liability Newsletter, Vol. III, No. 8 for October, 1971, describes the underwriting policies of California's professional liability carriers and analyzes the potential instability in this state's insurance market which may result from these underwriting policies. Although obviously conjectural, it is likely that physicians in the particularly vulnerable specialties (neurosurgery, orthopedics, anesthesia, etc.) who do not find themselves in a preferred risk classification will be faced in six or seven years with premiums of $10,000 for adequate liability coverage. American Mutual Liability Insurance Company, the one California carrier which neither seeks the preferred risk physician exclusively nor rates up certain of the insured within its group program, anticipates an increase in premium for all classifications in 1972. Will this drive many of their preferred risks to carriers who seek such physicians and will write them at a large saving? Will attrition in this preferred risk segment of their insured mix worsen the company's loss ratio, thus producing even higher premiums? The possibility of a vicious circle is obvious. As a rough estimate, perhaps one-quarter to one-third of California physicians covered by private carriers fail one common test for preferred risk status—that is, no loss (either settlement or verdict) in the last five years and no current open file against them. Over the next four years will the carriers who seek the preferred risk physician be able to maintain their rates, while the group carriers progressively raise theirs? Will groups, such as Hartford and CNA, which rate up some of their insured, be able to maintain favorable loss ratios by that means? Given the worst prognosis for the group carriers, extinction after a few more years, California physicians would find themselves in two classes: preferred risks who could obtain coverage at relatively reasonable rates and substandard risks insured at very high rates. It is the possibility of such changes which creates a feeling of urgency among those looking for alternatives to the current system of litigation.

[3]Instability in the professional liability market is created by a variety of uncertainties. For example, will judicial decisions over the next ten years further increase the doctor-defendant's risk of liability? In one area alone, that of informed consent, a single innovation (eliminating the need for an expert witness to establish the defendant's failure to warn adequately of risks incident to treatment) might sharply increase losses and certainly would increase the amount of litigation. Probably the most important uncertainty relates to the long "tail" on losses assigned to any particular year. Thus, in October 1970 a San Francisco jury awarded $500,000 for an anesthesia accident which occurred in May 1959. Because the patient was only 13 years old at the time, he had eight years plus the statutory period in which he could file suit. Assume that a company suffering such a loss had collected $2,000,000 in premiums in 1959. It is easy to see that what might have been a slightly favorable loss ratio for that year could be turned into an extremely unfavorable one. Is there an accelerating incidence of high losses such that even the high premiums in 1971 may not cover those losses attributable to this year which accumulate over the next 20 years or so? In the first three months of 1971 there was a $650,000 verdict in Los Angeles, $670,000 and $600,000 verdicts in Northern California and a $200,000 settlement in Northern California. These last three losses were against a single company. Early 1971 was also noteworthy for a 1.9 million dollar verdict against a Southern California manufacturer of intravenous solutions. The remainder of the year saw half a dozen verdicts in the range of one-half million dollars and a 2.7 million dollar verdict in Los Angeles against a drug manufacturer. These two drug manufacturer cases are mentioned only to illustrate what juries can do, given the appropriate facts; each of these two cases involved a single injured person. More importantly, these very high verdicts in the professional liability cases simply were not anticipated as recently as five or six years ago. Some actuaries have questioned whether standard methods are adequate to predict future losses in the professional liability field, given the variety of unstable factors affecting losses.

These are only the direct implications of the current system for the patient. Equally important, but more subtle, are the consequences of treatment made more expensive by "defensive" medical practices, such as laboratory evaluations and x-ray studies which are mainly designed to present a good record in case a suit should materialize.[4] The transferred cost of liability insurance from physician to patient makes care more expensive and promises to be of greater significance in the future. Finally, what can be said in defense of a system which, at least for some physicians who have suffered through litigation, places the patient in the position of being a potential enemy? How often does the patient, seeking only an honest explanation from his physician for an unexpected complication, find himself treated coolly, given little or no explanation, and left with the feeling that the physician's anxiety about a possible law suit takes precedence over his concern about handling the complication?[5]

For the social theorist, the current system presents a defect which he regards as more serious than those noted above. He sees the tort system as inadequate in terms of "outcomes measurement" and thus ineffective in promoting changes which are necessary to reduce medical injuries. That is, of the total number of medical injuries which occur, only a small proportion are actually litigated. Hence adequate data about injuries are not available to those who might promote medical improvement and reform, ultimately to the benefit of all patients. There are only a few papers which put forth the views of these theorists, but it seems they regard medicine as poorly motivated to accomplish adequate internal policing and look to leadership on this point from forces outside medicine.[6]

What about solutions? Parallel to more direct action, reflected in several pieces of legislation sponsored by the California Medical Association,[7] there has been a continuing effort at state and local levels to upgrade practice, especially within hospitals. Neither effort is a definitive solution: On the one hand, regardless of the efficiency of

[4]Of course, not all defensive medicine is bad. The physician who seeks consultation because he wants to protect himself in case of a bad outcome may be doing the patient a critical service when the consultant identifies some vital but overlooked facet of the patient's disease. Overuse of chloramphenicol unquestionably has been sharply reduced as the result of several well publicized law suits. The risk of liability for hospitals probably accounts, at least in part, for the variety of rules which benefits patients by imposing peer review, tighter procedures, and the like.

[5]Leonard D. Fenniger, M.D., former Professor of Surgery at the University of Rochester and currently Associate Director for Health Manpower at the National Institutes of Health, recently stated, "When the New York Times Sunday Magazine Section devotes seven or eight pages to an article by a physician in Washington describing the changes that have taken place and how he deals with the problem of the people who come to him for help and how much more defensive he has gotten over the last five years because of rising liability—when the New York Times devotes that much space to that kind of problem, I think it is fairly evident that it is much on everyone's mind. Ultimately, the present trends in medical liability actions will affect the choice of careers by individuals who may wish to go into medicine or into one of the health professions or one of the health occupations, but who decide that the risk is simply too great and, therefore, choose something that has less apparent risk. There will obviously be increasing effects on the availability of services and the choice of the services that are given to people who need them. In other words it may result in elimination of high risk but also highly therapeutic technologies simply because the risk and the threat are greater to the person continuing the practice of his profession than the gain that might be received by the patient through the use of a particular technique or a particular therapeutic regimen which has a fairly high inherent risk." And later in the same speech Dr. Fenniger said, "The increasing litigation, the rising cost associated with it, tend to produce an increasing number of elements that have absolutely nothing to do with the judgment based on medical knowledge or the well being of the person who is being served. I trust that there will be discussion on how one can go about making early settlements of differences. This is absolutely essential, not only from a dollar cost point of view, but particularly from an emotional and social point of view, because if one watches the devastation of a human being in a family while a case is in court for three or four years, the social cost is absolutely enormous and cannot be measured by any yardstick of dollars. We are all involved—we are all responsible in the last analysis. The decisions are going to be social and political, as well at medical and legal. Our best and generous advice is essential if the political decisions are going to the wise ones."

[6]It is frequently stated that federally sponsored health insurance will be a prime stimulus for more concern with quality control of medicine. There is an assumption that once a society satisfies its need for health care in a quantitative sense there is then an inevitable shift to concern for quality of care.

[7]A more restrictive statute of limitations, insulation of the minutes and records of medical review committees from discovery, the right to bifurcate a professional liability case so that the issue of the statute of limitations may be tried first, authority on the part of insurance companies to make advance payments to an injured patient without such an act being construed as an admission of liability, and immunity from liability for cardio-pulmonary rescue teams are all significant legislative achievements. A cost bond law and immunity from liability for the physician who in good faith takes over a case from another physician when a complication arises are statutes written in a manner as to make their value questionable.

postgraduate education, it is realistic to anticipate a certain irreducible incidence of negligent injuries as well as an additional incidence of medical complications which will lead to adverse verdicts even though there has been no substandard care. On the other hand, although legislation to date has been helpful, it is generally agreed that the medical profession cannot anticipate the sort of sweeping legislative change which would present a serious impediment to the plaintiff's pursuit of a given claim, especially where it is a valid one. Thus, in recent years informed physicians have directed their attention to substantial changes in the tort-courtroom system itself.

One change, which retains the tort system but eliminates the courtroom proceedings, is binding arbitration. California leads the nation in developing experience with this device. A substantial number of cases can be anticipated from Southern California-Kaiser which a year ago began requiring arbitration contracts with all of its members (more than 900,000).

Payment for adverse medical results without regard to fault (no-fault) eliminates the tort system altogether. This is the subject of this paper.

Payment for injury, regardless of the amount of care which was exercised by the defendant, is nothing new in Anglo-Saxon law. Although the question is disputed, a noted scholar, referring to English jurisprudence in the early 12th century, states, "The doer of a deed was responsible whether he acted innocently or inadvertently, because he was the doer. . . ."[8] and even 100 years later books which recorded the pleadings in the Royal Court revealed nothing resembling a negligence action.[9] The concept of due care seems implicit in a number of cases that were tried over the next 200 years, but it was not until the early 1500's that the Chief Justice of the King's Bench said, "It is the duty of every artificer to exercise his art rightly and truly as he ought." Subsequently this duty of care is referred to frequently in cases involving innkeepers and common carriers who lost customers' goods. But it was not until 1792 that an annual compilation of Royal cases offered an incidental heading which mentioned "negligence," and it was 1843 before negligence was treated as an isolated subject in an authoritative compilation of cases heard in the Royal Court.

The restrictions placed on the plaintiff's right of recovery in a negligence action were formidable in the 19th and early 20th centuries, and are usually attributed to a concern for unfettered development of burgeoning industry. Reversal of this trend began after World War I and has accelerated during the past 15 years. The rule of strict liability as applied to latent defects in manufactured products is an excellent example: The negligently manufactured product which causes injury will, of course, create liability for the manufacturer. But what about the defect in a product which is not discoverable in the course of careful manufacturing and inspection procedures? In a pioneering California case in 1963 the California Supreme Court ruled that, as a matter of social policy, the manufacturer should be required to pay. It was reasoned that if he could anticipate strict liability for injuries resulting from every defective product it would be a simple matter for the manufacturer to insure himself, whereas the injured party would generally be less well equipped to face financial losses. A similar rule of strict liability has been applied to food products for many years. The Pennsylvania and Illinois Supreme Courts extended the rule a year ago to include virus-contaminated blood. Recalling the degree of insulation from legal liability which the manufacturer and food producer enjoyed at the turn of the century, their present status implies an almost revolutionary change. And this change has occurred through judicial decisions rather than legislative fiat. The current trend in no-fault liability for auto incurred injuries reflects a similar concern for the welfare of injured persons, one which is codified by legislation.

It is in the context of this gathering wave of "consumerism" that one can best view the professional liability picture in California over the past 20 years or so. Our courts have frankly stated their intention to equal the balance between the patient who sues and the physician who defends by progressive expansion of the evidentiary rule of *res ipsa loquitur*. Juries, at least in metropolitan areas, also seem far more concerned than they were a number of years

[8]Wigmore, Selected Essays in Anglo-American Legal History (1894) p. 480.

[9]Percy Winfield, History of Negligence in Torts, Law Quarterly Review. Vol. 42, p. 184 (1926).

ago with the plaintiff's plight as compared with the physician's. Unquestionably there are additional factors (large contingent fees, the increasing skill of the plaintiff's bar, the public's increased awareness and acceptance of litigation), but most writers on the subject regard the physician's professional liability problem as fundamentally similar to that of others who provide a product or service for a fee—all share an increased risk of legal liability as compared with even 10 or 15 years ago.[10] In this context the physician's risk of professional liability can be seen as something other than an aberrancy; it is not an angry public "taking it out" on physicians. It makes sense, then, to assume that the peak of our liability problem is far ahead, and it is timely to look for some fundamental solutions.

Is no-fault liability for adverse medical results a viable solution? That is the question. Philosophical discussions on the point are interesting but defy accurate analysis because they depend so much on opinion. Besides, there is a basic issue which must be addressed first. Will it work?

This initial question takes precedence over the problem of financing a truly comprehensive no-fault system, although that would require premiums far in excess of those the medical community can foreseeably afford. And it is only indirectly concerned with administrative problems which, depending on the type of no-fault system adopted, could be staggering. Rather, the question is addressed to the most central issue in any compensation scheme, whether based on a fault or a no-fault system. That is, how does one identify the compensable events?

For some medical injuries it would not be difficult to establish causation in a no-fault scheme. Vesico-vaginal fistula following hysterectomy, for example, is a consequence of the operation. That is, but for the operation it would not have occurred. The surgeon's explanation that this can occur absent negligence carries no weight, because payment for the injury is made regardless of any question of fault. Virtually automatic payment in such a situation might be welcomed by the physician if it is alternative to a lengthy lawsuit, a two-week trial, possibly appeal, a possible re-trial, and so on. For the patient, there is an immediate financial recovery which, although probably smaller than a settlement or a jury verdict which might eventuate (and, on the average, the chances for a plaintiff's verdict with this particular type of injury would not be very good), is at least certain. And the money is available almost immediately, rather than a few years hence. The social theorist is satisfied because immediate payment for vesico-vaginal fistulas will soon supply his office with data concerning which physicians and hospitals seem vulnerable to this accident, and he can take action to remedy the situation. It is this sort of example, relatively clearcut injury after an easily defined medical intervention, on which theorists focus when they write about no-fault liability. But what about all of the other medical incidents (complications and injuries) which, but for medical treatment, would not have occurred? As discussed next, an evaluation which focuses on the cause of a particular untoward result of treatment, in order to decide if compensation is deserved, introduces complexities into a no-fault system which must strangle it.

Recognizing this defect in a no-fault system which is oriented toward analysis of treatment process, one research group in this field[11] has directed its efforts toward developing a "technology of treatment outcomes." This result-oriented approach is still in the conceptual stage, but it raises a number of important questions.

There are solutions which can be characterized as "partial no-fault" systems. One or another of these may have some real appeal, perhaps mainly because of their comparative administrative simplicity.

Compensable Events

A Literal No-Fault System

Taken literally, a no-fault system of compensation for medical "injuries" means payment for every unanticipated disability which, but for the medical intervention, would not have occurred. Albert Ehrenzweig, a professor of law at Univer-

[10]For the past four years the Inter-professional Committee of the San Francisco Medical Society has met with engineers, architects, attorneys, and other professionals in order to discuss a variety of topics within our common interest. With regard to their professional liability each has described concern. Construction engineers, and especially architects, currently have liability problems which, for some specialties within these fields, are greater than those faced by physicians.

[11]The Institute of Interdisciplinary Studies, Minneapolis, Minnesota.

sity of California, Berkeley, apparently advocated this literal rule as early as 1964 in a University of Chicago Law Review article.[12] Limiting his consideration to the hospitalized patient, Professor Ehrenzweig cited a study which placed the incidence of "hospital accidents" at 3.4 percent of all patients admitted. He says, "This insurance would enable the patient injured by a 'hospital accident,' i.e. *a failure in the process of his treatment* relating to services which were rendered or should have been rendered . . . . to claim the benefits of the policy without having to identify any specific injurer or a causative 'negligence' . . . ." And, "The patient would be assured a minimum recovery for any *injury to his health* that he might sustain for reasons other than those *induced by his illness* during his stay at the hospital." (Emphasis added.) In a recent, unpublished paper Professor Ehrenzweig's approach to the compensable event is the same.

Only a few illustrations are necessary to describe the scope of the problem (and it is undoubtedly greater than foreseen by Professor Ehrenzweig) raised by a literal no-fault rule. Shall every disease process which pursues its inevitable course to serious disability, or every death after coronary occlusion, after overwhelming bacterial or virus infection, after head injury, after hemorrhagic shock, and the like, provide survivors with a right of recovery only providing it can be shown that there was some omission, some alternative judgment, some more suitable intervention which would, in retrospect, more probably than not have saved the patient? These problems of judgment and omission (as opposed to the analysis of some specific intervention) bear special emphasis.

What of the physician who decides not to take an electrocardiogram when the patient presents to him with minor chest pains? When the patient dies of a myocardial infarction at home, a few hours later, it is the physician's erroneous judgment and his omission which account for the death. (Recall, we are speaking here of no-fault liability.) "Erroneous" in this context does not refer to carelessness, but only to a straightforward fact—but for the failure to identify the infarction with an EKG (assuming that the tracing would have been diagnostic at this early stage) the patient could have been admitted to a hospital and his life probably saved. Thus, because we are talking about a literal no-fault rule (being only concerned with causation) the issue of negligence simply doesn't arise.

And what of the patient with early gastric cancer who presents with mild indigestion, the bowel malignancy with only modest lower abdominal complaints, or the brain tumor with only a rather persistent but not severe headache? The physician's defense against a charge of *negligent* failure to diagnose a gastric cancer, a cancer of the lower intestinal tract, or a brain tumor will emphasize the reasonableness of any delay in performing an upper gastrointestinal series, proctoscopy and barium enema, or skull films and electroencephalograms. But again, a literal no-fault liability rule looks only to causation. If the patient with the indigestion has a gastric cancer and the physician waits before taking films, the only question which the patient, or his widow, seeking benefits need pose is whether or not the delay prevented cure.[13] So also with the lower intestinal cancer or the brain tumor.

Any physician can think of numerous similar examples. Two consequences of a literal no-fault system as it applies to judgments or omissions and a variety of interventions will be: First, a flood of administrative proceedings (probably on the order of industrial accident hearings) to determine whether or not the patient or his heirs have a right to benefits, and second, a pressure for defensive medicine far in excess of anything present today. It is clear how these two feed on one another—even though there is no onus of fault, the physician will want to avoid these administrative proceedings. They would take up a good deal of time, and for many physicians the nature of their practice would place them in these hearings several times a year. So even if there were no adverse consequences of repeated findings against the physician, it is inevitable that he would rapidly come to the conclusion that only a perfect set of records could constitute a reasonable "defense" in these cases.

[12]"Compulsory 'Hospital Accident' Insurance, a Needed First Step Toward the Displacement of Liability for 'Medical Malpractice'." University of Chicago Law Review, Vol 31, page 279 (1964).

[13]Obviously, even the most literal no-fault system would require *some standard* for evaluation of the physician's conduct. For example, how persistent would the gastric symptoms have to be in order to create suspicion? But create suspicion for whom? The *most alert* physician? This would be the extreme test. The absurdities growing out of a literal no-fault system are analysed further, below.

A literal no-fault system, as applied to the above cases, only requires establishing medical causation. But there is another group of cases where proving medical causation is just the first step in determining if the disability shall be compensable.

In these cases medical intervention is associated with a well defined, and not small, incidence of disability. Thus, chemical management of cancer is associated with an inevitable incidence of toxic reactions to the chemical. Aggressive as opposed to conservative management of a given case may carry a better ultimate prognosis for the patient, yet the aggressive treatment may carry with it a high risk of immediate and dramatic disability or death. In these examples, while it is true that but for the medical management the complication would not have occurred, the inevitability of complications makes automatic compensation seem unjust. And, far more importantly, to the extent the physician sees compensation as somehow a penalty against him, he will be reluctant to undertake medical management which carries with it the risk of these inevitable complications. Therefore, it probably would be administrative policy to deny compensation for those medically caused disabilities which were not only recognized risks of the treatment given, but, in the particular case at hand, truly unpreventable.

But how does one separate the preventable from unpreventable injury within this calculated risk group?[14] This can only be done by scrutinizing all aspects of the treatment process (the physician's judgment, the presence of any omission, and similar factors, and their relationship to the ultimate disability). Isn't it immediately apparent that this requires a standard of care analysis? Not in negligence terms, deciding what is "ordinary care" and then testing the physician's conduct against that standard, but in the frame of reference of actual causation. That is, was every aspect of his management, every facet of his judgment, so excellent that it is reasonable to conclude the complication was unpreventable? Alternatively, perhaps the physician could identify the particular disease mechanism which produced the complication and then demonstrate that neither could he have prevented that particular mechanism nor did he by his management promote it.

When Professor Ehrenzweig and other legal writers refer to medical injuries, they seem to select as their point of reference some specific intervention, usually surgical, which produces a reasonably obvious bad result. Yet, as I have indicated above, Professor Ehrenzweig would compensate any injury to the patient's "health that he might incur for reasons other than those induced by his illness during his stay in the hospital." Would it make sense to compensate only injuries resulting from *interventions*, excluding those resulting from errors in *judgment*? Of course not. This rule would reward the temporizing physicians in situations where delay could be unwise or even negligent.

Note especially that a literal no-fault rule requires that the administrative officer simply ask if a judgment was correct, not if it was wise. Thus, a physician who left his patient with acute myocardial infarction in a hospital which did not have a coronary care unit might be equally liable, if he guessed wrong, compared with the physician who transferred such a patient to a hospital which had a coronary care unit but the patient died on the way. If the administrative officer decided there was causation—that is, that moving the one patient caused his death or leaving the other in the hospital without the coronary care unit caused death—then compensation would have to result.

Comment: Is it not a virtual caricature to identify a no-fault system with such an impossible burden for the physician? A burden which, despite the elimination of an accusatory atmosphere, still must be very onerous as he finds himself in hearing after hearing, trying to explain every detail of his conduct. Therefore, if a literal no-fault system were introduced, it seems apparent that a standard of care which required perfection in medical management would be absurd. Similarly, the "but for" test which is implicit in a literal no-fault system, as referred to in my first group of cases above, would be far too strict. What

[14] A certain proportion of complications which are "within the risk" of a procedure would not have occurred if excellent judgment or technique or both were applied. And in a smaller proportion of cases injuries would not have occurred if ordinary care had been used. In other words, to say that a given disability is a calculated risk of a particular procedure does not mean it was literally unpreventable; it is only a statistical assertion which, in the defense of a professional liability case, is the first step in seeking to show that in the particular case at hand the complication was indeed unpreventable.

standard of care shall be required then? Excellent management? Very good management? An ordinary care standard would simply reintroduce the negligence system in a different form; so it would no longer be a no-fault system. But the necessity for introducing and then manipulating a standard of care in a literal no-fault system underlines its central defect: It is still an essentially accusatory system under another guise, one which may largely remove the opprobrium of a claim, but at the same time multiplies the number of claims many fold. The forum is shifted from the courtroom, but the requirement for detailed analysis of medical facts is not lessened.[15] Picture the conflict between experts, or expert and textbook, as the hearing officer seeks to determine the best standard of practice in a given situation!

Another common issue to be decided by the hearing officer at an administrative proceeding would be whether the particular judgment, omission or intervention, even if it were below the particular standard of care being applied, produced the disability of which the patient complained. This is similar to the familiar causation issue in negligence cases. Example: Granted that the doctor-defendant failed to identify a pulmonary carcinoma when the first definite signs appeared, if it can be proved that there were already metastases at that time, then his dereliction had nothing to do with the patient's death.[16]

And how would the administrative officer, in a no-fault proceeding, handle contributory negligence? Assume the patient is carefully instructed to notify his physician about a change in symptoms, and then does not do so. This could be treated as contributory negligence in a tort action, thus barring recovery. In no-fault auto injury schemes and Workmen's Compensation, contributory negligence is not a bar to recovery, although self-inflicted injury is. If a patient carelessly takes excessive amounts of a drug, injuring himself, is that a self-inflicted injury or contributory negligence?

Finally, regardless of the standard of care which the administrative agency applies, shall it be the same for the remote rural practitioner as for the metropolitan specialist? Again, because we are dealing with no-fault, the question of fairness (theoretically at least) does not arise. Thus, the protection which the rural practitioner receives from a sympathetic local jury or from legal rules which do not apply a specialist standard in evaluating his medical management (assuming that he was in a situation where no specialist was either indicated or could be obtained) would not be justified.

Compensation Based on "Comparative Casuality"

At a recent conference in Santa Barbara[17] J. W. Bush, M.D., presented a mathematical model designed to compensate patients for injuries traceable to "non-standard" medical management. The model seeks to establish a "coefficient of causality." This is derived in the following manner: Assume a patient suffered a fractured cervical vertebra incident to a fall. He was treated by traction with Crutchfield tongs, but treatment was unsuccessful and the net result was quadriplegia. Assume further that there is expert testimony that prognosis in this type of case would be slightly improved if the patient had been treated early with surgical decompression of the cervical spine. And, finally, assume that expert testimony establishes that there was only a 1 percent chance of recovery with traction alone but a 4 percent chance with the surgical procedure. The patient, then, was denied a 3 percent chance of recovery through failure to accomplish operation. In this example Dr. Bush regarded the total value of the disability as

[15]The no-fault rule for auto injuries is easily applied because it is easy to focus on the crash. Did the patient have a significant disability before that event? Is the alleged disability residual from the accident only a continuation of that which existed before? Only occasionally will these questions be especially complex, and even then the accidental event gives them a precise frame of reference. Similarly with no-fault liability as applied to industrial accidents. The great majority of time there is a particular accidental injury injury affecting a previously healthy individual. It is common to find lay commentators on no-fault liability for medical injuries treating the compensable event issue as differing only in degree from these examples. But it is apparent from the foregoing that there is a vital, qualitative difference: particularly in the area of judgments and omissions, the already ill patient who presents himself to the physician or hospital may have his illness prolonged, ultimate disability made more severe, a new disability (illness) introduced, etc., depending on what the physician does or fails to do.

[16]Since negligence requires not only a failure in due care, but a nexus between this and the ultimate injury, the physician would not be liable.

[17]"Medical Malpractice, a Discussion of Alternative Compensations in a Quality System," the Center for Democratic Institutions, Santa Barbara, California, September 1971.

$250,000. He identified the "coefficient of causality" as 3 percent (the difference between the 1 percent chance for recovery with traction and the 4 percent chance with operation) and 3 percent of the $250,000 gives a figure of $7,500. That is the patient's award for his quadriplegia.

Dr. Bush states, "The net effect in the long run is that all patients who are injured—under circumstances in which unacceptable medical treatment contributed to the proximate cause—would be awarded something, and the award would add up to the total amount of disability imposed upon the population by health care providers." He envisions authoritative medical panels, composed of physicians in the various specialties, making these determinations. He concludes that this system would readily identify the incidence of poor treatment results in a given community and that it has a particular advantage in assimilating "proven innovations in health care which would affect the determination of what is standard or non-standard" medical practice.

Comment: This system offers no relief from a detailed analysis of the medical treatment process imposed by a literal no-fault system. Additionally, the "comparative causality" concept fits into a fault rather than a no-fault frame of reference. Dr. Bush frankly states this fact. Yet the assignment of fault is associated with a very high standard of care (*i.e.*, would another treatment, another judgment, etc., have produced a better result?). This runs counter to the traditional feeling that retrospective assignment of blame, applying such a high standard, is unjust.[18]

A Result Oriented No-Fault System

R. J. Carlson, a research attorney at the Institute for Interdisciplinary Studies in Minneapolis, presented a concept at the Santa Barbara Conference which seeks to finesse causation issues altogether. It is Mr. Carlson's premise that "compensation for medical injuries should be tied to the degree of deviation of a given result from a set of expected results for like procedures." That is to say, "If the health care industry is conceived as an enterprise occasioning compensation for those who suffer harm through the conduct of that enterprise, a determination must be made whether or not the patient's prognosis at discharge (or at the time of filing a claim) is 'worse' than it should have been, or 'worse' than expected, *given* the procedures and regimen of care utilized for that patient. This is required unless a social insurance system unique to health care is created which would compensate any state of disability occasioned by health care even if the result of care was wholly expected. For example, a gangrenous leg must be removed; if it is removed, the patient has one less leg and would therefore be compensated for that loss."

Comment: The implications of a social insurance system for medical disabilities is considered under a separate heading below.

For physicians this concept seems peculiar, because our orientation is toward accurate evaluation of medical events. So a reparations systems which is inefficient in identifying the individuals to be compensated seems both clumsy and unjust. But the "social engineering" implicit in Mr. Carlson's concept is not focused primarily on justice for the injured individual, rather it is designed to improve the health care system. Thus, it is envisioned that compensation for unfavorable outcomes of medical treatment would bring to the attention of the administering agency (and this could be medical or public or a combination of both) a very large number of cases. It is postulated that additional analysis of these cases would be undertaken, not to clarify further the accuracy of the decision to award a given patient, but to evaluate the competency of the medical care. Then data accumulated about quality of care would serve to bring pressures, of a nature undescribed by Mr. Carlson, on the "health providers," whether physician, hospital, or other, to the end that effectiveness of services might be improved.[19]

Does this "outcomes analysis" only look to results as a basis for compensation? This is not literally true, because it is a deviation from

[18]It was suggested at the Conference that Dr. Bush's comparative causality analysis might have its best aplication to rare medical or surgical accidents which are a calculated risk of a given treatment or procedure. Thus, if vesico-vaginal fistula is preventable by excellent surgical technique and judgment 85 percent of the time, but is unpreventable 15 percent of the time, then a standard award for this disability could be reduced by 15 percent.

[19]Mr. Carlson puts it this way: "While assessments of compensation are made without references to the behavior of the providers, once compensation issues have been resolved 'process reviews' of provider behavior (and other 'disciplinary' mechanisms) to correct sub-performance ostensibly contributing to (if not proximately causing) the claim in question can and should be made."

expected results which rings the compensation bell. So it is inevitable that the prognosis in a given case be based on something more refined than an admitting diagnosis. Therefore, some additional data about the patient's presenting condition will go into the equation, but this will fall far short of the detailed evaluation necessary to establish medical causation. As Mr. Carlson stated in his Santa Barbara presentation: "A no-fault system strips away the interrogative aspects of malpractice and focuses instead on the nature and extent of a patient's prognosis. The physician is no longer made the subject of an extensive examination in order to determine whether any recompense will be made; nor is the concern, for the purposes of compensation, with discrete provider behavior in an episode of care."

Obviously the next question is, Who shall decide when there has been a "deviation from expected results?" Speaking in Chicago in March of last year,[20] Mr. Carlson noted: "A compensation system for medical injury not based on fault would require the development of norms or scales of health care outcome. This is an enormously difficult scale to develop, and I would like to add, parenthetically, that the resource organization with which I am working and particularly a research project with which I am involved is looking at a no-fault compensation system for medical injuries. We have been looking at it for eight months and I suspect we will be looking at it for a lot longer than that. The toughest question of all to deal with in medical care is that of a technology available to develop scales of outcome. We haven't resolved this question, although we have contacted, talked with and have had conferences with, the leading experts in the country on the question of outcomes for health care. We think we are breaking some ground. We think we will be able to develop some tentative scales for health care outcomes."

When Mr. Carlson talks about departure from an anticipated result, his usual frame of reference seems to be a case where there is some specific intervention, most often in a hospital environment. But what of this analytical approach in more subtle situations, for example the failure to make a diagnosis in an office practice? Take the patient who is seen by her physician every few months and develops a breast cancer during this time. Or what of the patient who presents with a mild febrile illness which is treated with aspirin, then goes home and develops a fatal meningitis? What if the fever was low grade, the sore throat mild and these occurred when a number of patients in the community were manifesting epidemic virus respiratory infections? Were the patient's parents carefully instructed to contact the physician within 24 hours and did they then not do so? Is it reasonable to suppose that the meningitis wasn't present at all when the patient was first seen, developing only later from the upper respiratory infection? It is one thing to talk about a "deviation from expected results" where there has been surgical operation, but how can one talk about the "expected results" in this meningitis case without analyzing every facet of the presenting problem and subsequent course? Similarly with the breast cancer example. How often was the patient seen, how often were the breasts examined, what were the notations in the medical record, and what was the location of the cancer once it was identified? Was there metastasis by that time?

In cases involving less than optimal judgment, and assuming that this accounts for disability, what does the "technology of outcomes" do for us? Assume there is a mistaken diagnosis. Can this technology simply look at the number of days before the full blown, recognizable disease that the patient was seen and then draw conclusions concerning the presumed adequacy of the physician's diagnostic guess? Every time he guesses wrong, and the patient suffers because of the delay in accurate diagnosis, shall there be compensation? More importantly, how does the outcomes approach handle an allegedly substandard judgment in the course of a highly complex disease process?

For example, a physician makes one or more judgments in the course of treating a patient with severe diabetic acidosis. For the sake of argument, assume that at least one of these judgments was clearly negligent and caused the patient's death. Can a system of compensation avoid being capricious without a careful analysis of treatment process in cases of this type? This leads right back to the complexities and absurdities of a literal no-fault system.

[20] "A Conference on Liability for Medical Injuries" sponsored by the Comprehensive State Health Planning Agency, State of Illinois, March 1971.

Perhaps the advocate of outcomes analysis would argue that death following uncomplicated diabetic acidosis will be considered a deviation from an expected result. This finesses the treatment analysis. But what if the patient in my illustration entered the hospital with a variety of complications? Perhaps he was in shock, had early heart failure and auricular flutter. Is this a case in which, should the patient die, there should not be compensation? Now assume that each of these complications was swiftly and effectively treated by the intern or resident staff, the errors being effected later on by the patient's private physician? How can the case be shifted back to the compensable category without an analysis of the treatment process?

More commonly, there is the uncomplicated illness which becomes complicated, and unpreventably so, during treatment. If there is residual disability, shall there be compensation just because the initial diagnosis implied a favorable outcome? And if the physician is permitted to "defend" by putting the complication in "evidence," the patient must be allowed to rebut by arguing it was preventable. So the standard of care issue must be analyzed through expert testimony, or textbooks or both, and the parties again face the same problem as in a literal no-fault system.

To the extent that less than satisfactory results of treatment are characterized as deviations from expected results (and keeping in mind that this system does not include significant analysis of the treatment process) many physicians will regard this approach to no-fault liability as capricious. In view of Mr. Carlson's suggestions (considered below) about regulation of physicians based on data concerning medical injuries, it is inevitable that physicians would come to regard the system as accusatory. In a variety of areas, therefore, and especially with regard to diagnostic judgment (does this patient need an EKG for a mild chest pain, does this baby require treatment in hospital for what seems to be self-limited diarrhea, should this patient with nonspecific gastrointestinal complaints have an x-ray study), there is the likelihood of defensive medicine with a vengeance.

Comment: It is important to note that Mr. Carlson regards the "technology of outcomes analysis" as undeveloped at the present time. In a recent conversation he told me that his scheme is only a "social and conceptual approach to a problem" and does not pretend to be a solution which has been filtered through a large number of evaluations by clinicians in order to test all facets of its applicability or acceptability to the medical profession. However, his project is important because it represents the most intensive study of this particular no-fault approach, and it is on-going. It is planned that Utah will run an experimental program, purely on paper, without any implication for payment to patients or discipline of physicians. The current interest in no-fault in the country is illustrated by the appearance already of a bill in one of the smaller state legislatures, proposing no-fault liability in malpractice cases.

At Santa Barbara Mr. Carlson made these observations about the implications of "provider self regulators" associated with his plan: "There have been two reasons for the failure of much provider self regulation thus far. The first is that regulatory systems have been and are controlled by providers, violating a fundamental precept of regulatory theory. Paradoxically, however, the capture of the disciplinary process has not been covert but designed by state enabling legislation, mandating provider controls of the disciplinary machinery. The second reason is that, while competence is acknowledged to be important by providers, lacking definitive measures of competent performance, disciplinary proceedings have not been based on such grounds. This in part is because providers have been able to argue that to do so will be both unfair and capricious. Of course, state laws with rare exceptions have not recited 'competence' as a ground for disciplinary action, but such statutes are virtually dictated by organized medicine in most states and thus only mirror the prevailing sentiments of providers on the question. A shift to no-fault compensation should, however, increase the likelihood that disciplinary statutes will reflect a concern for competent performance; utilize such indisputable evidence of provider's subperformance as is available through recorded process reviews of provider behavior occasioning claims; and finally relax the grip of providers over regulatory agencies by lessening their concern over consumer involvement because the judgment to be made in disciplinary cases are less subjective and presume less expertise under no-fault. All of

this can be reasonably expected because a no-fault system is ostensibly more compatible with the professionals' view of the appropriate means to assess competence and penalize incompetence."[21]

Comment: Regulation in the context of a thoroughly rational system, one which accurately identifies sub-standard practice and seeks to correct it through reasonable means, probably would be welcomed by the majority of physicians. But in the context of a system which frequently must seem haphazard in its selection of compensable events, it is inevitable that the resulting regulatory efforts would be viewed with great suspicion, especially if a significant part of the regulation were to come from outside the medical profession. That this suspicion would create demoralization within medical ranks, with a variety of unfavorable consequences, is obvious.

[21]Mr. Carlson is interested in a technology of outcomes analysis because he sees it as an efficient way of identifying compensable events in a no-fault system. But this technology has another application; it is being developed in anticipation of a greatly increased concern for quality of health care delivery. This concern on the part of organized medicine in California is apparent, and it is assumed that those states which are laggard will be stimulated by federal intervention as the government becomes increasingly involved in health insurance. Especially where outcomes analysis is combined with informed, even though cursory, evaluation of medical treatment process it seems apparent that reasonably adequate estimates can be made concerning competence of the care delivered. Those concerned with this technology believe that concern with treatment process can decrease as their outcomes analysis becomes increasingly refined. For those who accept the implications of control inherent in this developing technology, the inevitable lack of precision, and therefore the chance for error in a specific case, does not constitute a serious flaw. It is reasoned that careful analysis of cases which are erroneously identified as "deviations from expected results" will identify the system's error. I mention this application of outcomes analysis because its apparently reasonable application in the area of quality control may have made it seem attractive for, and applicable to, the matter of determining the compensable event in a no-fault system. But there are vital difference: First, it is not the patient's right to recovery which is being vindicated by an outcomes analysis as applied to quality control. There is not a flood of cases being processed by an administrative agency, each with an attorney asserting the validity of his client's case, many of these cases perhaps being without merit. Second, there is no need for "litigating" the standard of care issue in such cases as are described above. Most importantly, the standards applied in a quality control evaluation can be realistic and flexible. Third, the physician "charged" with a particular untoward result of treatment neither wastes time in an administrative proceeding nor is forced to defend himself in public. Finally, a quality control enterprise probably would have sufficient peer participation so that most physicians would accept these regulatory pressures with good grace. The introduction of attorneys into the no-fault system would, for many physicians, produce the opposite effect.

Restrictive No-Fault Systems

There are three additional approaches which have as their point of reference an unanticipated result of treatment, but in each case the compensable event is narrowly defined.

The most restrictive concept is offered by Hansen and Stromberg in a November 1969 article in the Hastings Law Review.[22] This article reviews several aspects of hospital liability and gives relatively brief mention to a no-fault system for hospital injuries. The authors define a compensable medical accident as an unexpected result, but one which would "have to refer to a result unexpected according to medical knowledge at the time of treatment." They said further that "the phrase 'unexpected result' should not be held to include infections or complications which occasionally occur from the kind of treatment administered, even though the infection or complication might occur in a very small percentage of cases." In other words, untoward results which are a calculated risk of the medical treatment would go uncompensated.

Comment: Where the injury is rare, the assertion that it is a calculated risk of treatment (usually surgical) is a common defense in a professional liability action. As discussed above, almost all such injuries are medically caused although there is a sound basis for excluding compensation when the complication is truly unpreventable; for example, a toxic reaction to necessary drug therapy. But where the rare injury results from surgery, this is precisely the sort of event which all other no-fault systems compensate. And under the present tort system, recovery for these injuries is not uncommon when the plaintiff's attorney is able to show some deviation from standard care associated with the accident. Of course, where an "unexpected result" is not a calculated risk of treatment, tort liability probably will result because the physician cannot explain away the occurrence. In California *res ipsa loquitur* applies to these cases.

The second plan, which has been discussed for a number of years, involves "trip insurance" for

[22]"Hospital Liability for Negligence," The Hastings Law Journal, Vol. 21, page 1, November 1969.

the patient in hospital. As generally conceived, this coverage would be limited to surgical patients. In return for insurance protection which would cover any unanticipated consequence of treatment, the patient would agree not to sue the physician for negligence. Such insurance raises two preliminary questions: First, would the California Supreme Court allow this hold harmless (exculpatory) contract between doctor and patient, or would it be void as contrary to public policy. Second, even if the contract were legal, how would the parties differentiate the treatment-related injury from some adverse consequence of the patient's disease process?

The first question focuses our attention on a 1963 California Supreme Court decision, Tunkl vs. Regents of the University of California.[23] In this case the patient had signed a contract upon entering the UCLA Medical Center in 1956 which released "the Regents of the University of California and the hospital from any and all liability for the negligent or wrongful acts or omissions of its employees, if the hospital has used due care in selecting its employees." The courts found this contract invalid as contrary to the public interest. Why? It was because of the hospital's decisive bargaining strength, the practical necessity and importance of the service to the patient, and also because the contract made "no provision whereby a purchaser may pay additional reasonable fees and obtain protection against negligence."

It seems obvious then, that a bare contract which sacrifices the patient's right to sue will be invalid. But especially where the hospital paid the premium, it is interesting to speculate if adequate insurance payments for surgical injury, without regard to fault, would be considered by the California Supreme Court as a *quid pro quo* for the patient's forfeiture of his right to sue.

There remains the second question: How shall the untoward result of treatment be defined? Controversy on this question could be prolonged, as discussed above. The following partial solution has been suggested: Consider the fact that elective operation on patients who are excellent risks (who have no complicating diseases, are not elderly, and other such factors) is the background for an almost certain lawsuit where catastrophic surgical, or post-surgical, injury occurs. And it is these cases which are likely to yield the highest jury verdicts. Also, in these cases the complications probably will not be part of the patient's disease process, but rather will be treatment related. Therefore, why not ignore the causation question and only look to the result in determining whether such patients should be compensated?

A broader approach is suggested by the following plan: Upon entering the hospital the patient's physicians would write a prognosis on the chart. Where the result of treatment substantially deviated from the prognosis, the patient would have a choice of receiving no-fault compensation, and giving up his right to sue, or of pursuing his tort remedy. This approach probably would not be applicable to the particularly complicated case. And the physician's prognostic statement probably would have to be more complete than a couple of words. But the plan has the virtue of avoiding most causation questions (presumably if the patient died of an unrelated coronary occlusion, for example, this fact could be introduced to defeat compensation) and there would be no problem of validity of the contract, since the patient or his heirs would not agree to forfeiture of his tort remedy until after the injury.

Constitutional Questions

California's State Constitution does not guarantee a jury trial in civil cases, although this right is provided by statute. And the Seventh Amendment to the United States Constitution, providing for a jury trial in civil cases where the amount in litigation is more than $20, applies only to federal court cases. (It is not, like the Sixth Amendment which provides for jury trial in criminal cases, a federal constitutional protection which extends to the state courts.) Thus, the California legislature could establish no-fault liability in malpractice cases if there were no additional constitutional issue.

But there is. A no-fault system does not just deny a jury trial to the parties in a professional liability action; they are also denied access to a judicial system based on tort law and its theory of recovery. Is there a constitutional impediment to such a wholesale substitution of one system for another? It is the equal protection clause of

[23] 60 Cal. 2d 92, 1963.

the Fourteenth Amendment of the United States Constitution which is relevant here. This requires that a group which is selected for different treatment (that is, tort actions against physicians and hospitals are eliminated but not tort actions against others in society) must be *reasonably* selected—that is, an analysis of all of the facts must show a sound basis for the separate classification of the group, and the social benefit must outweigh the social harm incurred.

In speculating on the constitutionality of the no-fault liability system for medical injuries, it is useful to consider no-fault in automobile collision injuries. There the justification for legislation is abundant. Jammed calendars in metropolitan areas, steadily rising bodily injury insurance premiums, the enormous incidence of auto injuries, the comparatively small percentage of the premium dollar which goes to injured patients, all attest the reasonableness of the law. Yet, in the four or five states where it is operative the no-fault auto statutes address themselves only to the comparatively minor injuries, leaving all of the rest to the tort system.[24]

Considering the sweeping change involved in a literal no-fault system for medical injuries, it is likely the California Supreme Court would require very persuasive reasons for such a law. In a recent conversation with a Superior Court judge who is known for his scholarship in constitutional law, he repeatedly brought up the importance of thorough documentation to support the contention that serious ills would be escaped and substantial benefits gained by a no-fault system.

Social Insurance

Social insurance, also termed a social security system for compensation, is defined by its scope of application. Most narrowly, it simply means government financing of a disability insurance system, and the rules for identifying which medical injury deserves compensation might be no different than those discussed above. However, in the ordinary sense, a social insurance system for medical injury compensation would disregard all facts of the case except the fact of disability and that the disability arose in relationship to the medical treatment system.

Thus, a patient who entered the hospital with two legs and left it with one, even though the amputation was made necessary by a malignant lesion of the bone, would receive compensation. Two difficulties are immediately apparent.

First, what of the patient who suffers severe low back pain and, following surgical operation for example, finds himself no better. Since medical treatment has not increased his disability, he presumably would not be compensated. But what if he is no better because of negligent management? As the social insurance plan has eliminated tort remedy, he can receive no compensation. And what if, in fact, he is no better and no worse, but contends that he is worse? This must require an administrative proceeding, which could be quite detailed under some circumstances, in order to determine the validity of his claim.

Second, and far more important, note that it is the nexus with some feature of the community's health system that provides for the patient's ultimate financial recovery. If he has a headache, enters the hospital and leaves with hemiplegia from a stroke, he will be compensated. But if he has a headache and is treated by his wife and has a stroke at home, he will not be compensated. This is an obvious injustice for the patient but it has a far more critical effect on the medical community. A social insurance system with this inequity would force every individual with any complaint which *he thinks* might culminate in a permanent disability to obtain medical supervision. Such a system would decrease self-reliance and at the same time grossly overburden the community's health care facilities.

Rationality as well as justice in a social insurance system would seem to be achievable only by payment for every disability, regardless of the patient's medical background or relationship to some health care service. Such a feature of a welfare state is, of course, enormously expensive and social theorists have argued for and against such a final shelter from life's vicissitudes. Suffice to say that social insurance, regardless of the scope of its application, seems to most sociologists a far off prospect for American society.

[24]From the physician's viewpoint it would make no sense to have a no-fault system covering only small medical injuries. These are seldom litigated in the current system. On the other hand, for the patient this would be a substantial benefit. Under the present system, even where there is relatively clear liability, if his loss is only one or two thousand dollars and there is no residual disability, it is not profitable for a competent malpractice plaintiff's attorney to pursue the case.

Arbitration as an Alternative to No-Fault

The well known rigors of court trial, along with the delay before a suit is finally closed, have attracted many physicians to the no-fault concept. However, arbitration can yield these benefits without the serious drawbacks of a no-fault system.[25] In fact, from the physician's viewpoint, the value of arbitration must be determined by a comparison with the tort, rather than no-fault, system.

Binding arbitration in professional liability cases was, until recently, unique to California. It has been used at the Ross-Loos Medical Group since 1931. A hospital pilot program in Southern California, co-sponsored by the California Medical Association and the California Hospital Association, has been in progress for two years. Southern California-Kaiser Health Plan has required arbitration contracts of its patients since January 1971. Private physicians have had access to arbitration through an insurance carrier, Casualty Indemnity Exchange, for the past two years.

The cases at Roos-Loos are neither sufficiently numerous nor adequately representative (a very high proportion of cases where there is a significant risk of liability are settled) to permit firm conclusions about the value of arbitration. It is virtually certain, however, that during the next two or three years enough cases will proceed through arbitration, especially in the Southern California-Kaiser experience, so that its value may be finally determined.[26]

A discussion of arbitration is outside the scope of this paper. Copies of my paper on this subject, presented at the Center for the Study of Democratic Institutions last September, are available upon request.

[25]The term *arbitration* is used to signify "binding" arbitration as opposed to panel arbitration. The former is permitted by law in 26 states, is a substitute for courtroom litigation, and permits only a limited appeal from the arbitrator's decision. The latter is usually advisory only, with the panel's decision placing no obligation on either party, although a decision for the plaintiff is associated with the guarantee of a medical witness in case settlement is not achieved. Binding arbitration requires a contract between the parties (usually achieved before establishing the treatment relationship) whereas the agreement to arbitrate before a panel arises after the injury.

[26]HEW's Commission on Medical Malpractice has ordered a study of both panel and binding arbitration. The results will be available this year.

Discussion

A no-fault system for compensating injured persons cannot be analyzed outside the context of the injury. The compensable event for the automobile accident victim usually is obvious. For the patient who suffers an untoward result of medical treatment, it frequently must be enormously subtle. In such cases, pursuit of the question leads right back to a standard of care analysis, conflicts between experts or textbooks or both, lengthy hearings, and even the accusatory atmosphere—all of which the physician seeks to escape by finding an alternative to customary courtroom litigation.

Theorists such as R. J. Carlson have recognized this trap in a literal no-fault system, and so a result-oriented plan has been suggested. Perhaps the simplicity and utility of "outcomes analysis" as applied in medical surveys designed to improve quality of care make this approach seem applicable in identifying compensable events for a no-fault system. However, the difference between their immediate purpose and the method is crucial: For quality control the problem is to gather enough information for evaluation in order that pressures may be brought which will, ultimately, stimulate participation in continuing education, improve techniques and procedures, limit certain physicians in their scope of practice, and so on. The agency using the data, that is, the "outcomes" of treatment in a given community, probably would vary its criteria for assigning "fault" from time to time. Such questions would be relatively incidental compared to the problem of effecting improvements in medical care and gaining the cooperation of physicians in the community. Compare this to the result-oriented no-fault system.

Its immediate purpose is to compensate a patient. He brings the claim, he has an attorney, they are concerned with a "correct" (that is, favorable) application of the rules in their particular case. The physician and his attorney can be depended upon to resist the claim, especially if the consequence of repeated adverse decisions will be a limitation of the physician's scope of practice.

So precision is demanded of the result-oriented system, at least to the degree that physicians generally will not feel compensation decisions are handed down in an arbitrary manner. In a great

many instances, especially where diagnostic judgments are involved and also where there are unusual circumstances associated with the treatment process, detailed analysis of the case will be required. If such analysis is not provided, then either side may regard the system as frequently unjust. Yet the required analysis leads right back to the complexities and absurdities of determining compensation in a literal no-fault system.

Limited no-fault systems carry a certain appeal. Trip insurance for the uncomplicated case, especially in a relatively young patient undergoing elective surgical operation, is considered rational by many observers. It is dramatic complications associated with that sort of case that account for a good proportion of very high jury verdicts and settlements.

Financing of a comprehensive no-fault system would be prohibitive. An objective of no-fault compensation in the automobile and industrial accident field is to transfer as much of the premium dollar as possible to the injured party. But, for reasons stated, a comprehensive no-fault approach for medical injuries would lead to extensive hearings in a large number of cases.

It is worth re-emphasizing that patients ordinarily do not enter the continuum of medical care unless they are ill. In a literal no-fault system it would be easy for patients to regard a less than satisfactory outcome of treatment (and this is in terms of their own expectations, which might be unrealistic) as a basis for compensation. Especially would this be true if there were significant disability. Unmeritorious claims could drown the system in administrative proceedings. A result-oriented system might reduce the number of claims, but this is only speculative. Limitations on the patient's right to a detailed analysis of the treatment process should permit the hearing officer to dispose more easily of the invalid claims. However, as discussed above, rules providing ease of administration would virtually guarantee dissatisfaction with the "unjust" result in a significant number of cases. Thus, in order to avoid arbitrariness, detailed treatment analysis would be necessary in many cases, leading right back to the complications which a system of outcomes analysis is designed to obviate.

I have avoided a discussion of social philosophy. It may be enough to point out that an imposition of absolute liability for manufacturers and food producers expresses a growing attitude that those who are injured should be compensated and those who can distribute the cost of insurance should be burdened with payment. Equally important, such a rule is widely accepted as contributing to greater care on the part of the producer. It is plain to physicians that there is not the remotest analogy between an industrialist and the private practitioner. But if comprehensive federal health insurance is followed by an increasing number of health maintenance organizations, perhaps medicine some day will be regarded as far more monolithic than it is at present. At that time will special burdens, of the sort discussed here, be placed on physicians?

Social theorists make it plain that quality control, rather than patient indemnification, is the most important goal in a no-fault system for adverse medical results. Broad and effective action by the medical profession to initiate peer evaluations and controls would reduce those pressures which may develop in the future for a no-fault system.

It is important to make a final point, although it is one which is difficult to quantitate or even describe. Physicians appreciate as almost no others can the difficulties and psychological stress which are involved in medical decision making. It is currently fashionable to feel little sympathy with this professional group who have been in a seller's market for many years and who, while admittedly working long hours, enjoy a level of income which is generally regarded as very high even in these inflated times. It is easy for critics to forget that good medical practice requires the freedom to make choices with only medical considerations in mind. These choices are often difficult. The physician, in retrospect, sometimes may realize that alternative choices would have avoided serious disability or even death. Yet the possibility for such unfavorable outcome of a given decision is faced by most physicians frequently. To the extent that the medical community develops the feeling they are being subjected to unwarranted interference in the conduct of their profession, this sense of harassment cannot but interfere with medical decision making.